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Annual Oration

The Doctor's Dilemma: Clinical Governance and Medical Professionalism

Royal Victoria Hospital 2010

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I would like to thank Dr Beringer and the Medical Staff for the privilege of giving the oration. Two duties fall to me this morning. The first is to welcome the new medical students to the Royal Victoria Hospital and this I do most warmly.

My second duty is to offer some thoughts on a subject related to medicine. The topic is entirely of my choosing and I approach my task conscious of the risk that you are subjected to the ramblings of someone approaching the end of his medical career – the danger of giving a grumpy old man a platform. Some of the matters that I wish to discuss have caused considerable distress to our profession in recent years. But then, no challenging enterprise is going to be comfortable all the time.

I should begin by confessing a bias. It is that the answers to many of our questions are to be found in history and literature. Simply stated, if we want to understand our present position, we need to understand how we reached it.

And so I come to the first part of my title. George Bernard Shaw's play, *The Doctor's Dilemma,* was first produced in London in November 1906. It was published five years later with a 'Preface on Doctors' almost as long as the play itself. The subject of the play was one which remains topical – the distribution of limited resources. The dilemma confronting the doctor, Sir Colenso Ridgeon, was that he was able to treat only a limited number of patients with tuberculosis and he must decide between the talented, but feckless artist, Louis Dubedat and the worthy, but ordinary young Doctor Blenkinsop.

Shaw was friendly with Sir Almroth Wright who was Professor of Pathology in St Mary's Hospital Medical School, the department where Alexander Fleming discovered penicillin. Wright was a polymath, conversant in literature and philosophy. As a youth he had lived in Belfast where his father was vicar of St Mary's Church on Crumlin Road. He attended the Royal Belfast Academical Institution for a time, but was educated mostly by his parents and tutors. He studied languages and medicine simultaneously in Trinity College Dublin. Shaw, by all accounts, often visited the library in Wright's department where he enjoyed hearing the unguarded conversation of the medical men. When one of Wright's young assistants complained that the Inoculation Department had more work than it could manage and had to select who should receive treatment, Shaw had the idea for his play. Wright walked out on the first night of the play, not because Shaw had caricatured him, but because he disagreed with Shaw's choice of whom to treat.

Shaw addressed one medical dilemma in his play, but in the preface he discussed many others. He dealt at length with vivisection, of which he was a trenchant opponent. He was also strongly opposed to private practice and thought that paying doctors according to the complexity of the treatments they provided was as illogical as paying judges in proportion to the severity of the punishments they handed down. He concluded that "Until the medical profession becomes a body of men trained and paid by the country to keep the country in health it will remain what it is at present: a conspiracy to exploit popular credulity and human suffering"[1]. Other objects of his attention included whether medicine was a science or an art – he thought that it was an art - and the misinterpretation of statistics and evidence. Little escaped him; he even had an opinion on the psychology of surgeons. Whilst Shaw was often critical of doctors, he blamed most of the problems on the circumstances in which they had to work. In moral terms, he considered them no better or worse than the rest of the population. All the professions were, in his view, conspiracies against the laity. In 1930 he wrote of the need to bring the medical profession under responsible and effective public control, advocating lay representation on the General Medical Council.

In recent years, regulation of medical practice has achieved a prominence which Shaw could hardly have imagined. My main theme for this morning is to consider the methods used to regulate and control medical practice. The term clinical governance entered the consciousness of doctors with the publication of a white paper, *The New NHS: Modern, Dependable*[2] in December 1997. There was much uncertainty as to what exactly was meant by clinical governance and how it would affect practice. The idea of governance was not new; it was adopted from the corporate business world and its origins there yield some insight into the effects that it has had on medicine. Misdemeanours by directors and executives resulted in the collapse of business and financial organisations and, as a result, a committee chaired by Sir Adrian Cadbury was set up in May 1991. What came to be known as the Cadbury report was published in the following year. Ten further reports and codes of conduct were produced in the next thirteen years. Then came the Companies Act of 2006. The Financial Services Authority commenced a review in 2002 to include corporate governance and the Financial Reporting Council established a committee in 2004

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specifically to deal with corporate governance. With all this regulation, shareholders and investors might have thought that they were quite well protected – until the catastrophic failure of Northern Rock in 2007 and the Royal Bank of Scotland in 2008. There are three obvious lessons. First that regulation is difficult. Secondly, that regulations tend to proliferate, and thirdly that they were not effective, at least, in the corporate world.

What then of clinical governance? It was driven by a number of instances in which there was widespread media coverage after patients had been damaged. In Bristol in the late 1980s and early 1990s a high death rate following some paediatric cardiac surgical operations led to the largest inquiry the General Medical Council had ever undertaken and to a hearing lasting 74 days. Two doctors' names were erased from the Medical Register and a third had restrictions placed on his practice. Harold Shipman was arrested for murder of patients in 1998 and convicted two years later. Rodney Ledward and Richard Neale, both gynaecologists, were struck off the Medical Register, but there was criticism of the length of time taken to identify and act upon their poor practice.

The White Paper that introduced the concept defined clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence of clinical care will flourish". Clinical governance was to be achieved by:

Application of evidence-based care

Use of clinical guidelines

Clinical audit

Professional education

Research

Risk management

Individual appraisal and re-validation

All of these are worthy objectives, but could deliver only if implemented effectively. None has been, at least so far. Evidence-based practice has been misinterpreted as the simplistic enforcement of rules. The requirements of good quality clinical audit have not been recognised so that it has not achieved anything approaching its potential. The importance of professional education was acknowledged in the consultant contract, but time for supporting professional activities has been a casualty of financial pressures. Clinical academic departments have been emasculated in recent years with the loss of much potentially valuable clinical research. Risk management is now a mature discipline with a significant research base, but even its most basic principles have not yet been adopted by NHS management. After the Bristol case, the GMC brought forward the idea of re-validation as a means of ensuring that practitioners continued to perform effectively throughout their working lives. That was in 1998 and no functioning system of re-validation has yet been devised. Annual appraisals continue, but their effectiveness remains to be shown. Sir Gerry Robinson had a view on appraisal in the business world. He said: "I hate appraisal systems. The best way of tackling a staff issue is to do it instantly...[3]"

So, the experience of implementation of clinical governance has not been good. If its objective was to ensure the quality of care for patients and prevent news stories of the kind which contributed to its introduction, it did not succeed. In March 2009 a report by the Healthcare Commission of poor care and excess mortality of between 400 and 1200 patients in Mid Staffordshire Hospitals made headlines. Stafford Hospitals were a foundation trust, a status achieved because their management procedures were considered of such quality that they could be allowed greater autonomy in running their affairs. Robert Francis QC, in the report of his inquiry[4], said "The story of Stafford shows graphically, and sadly, that benchmarks, comparative ratings and foundation trust status do not in themselves bring to light serious and systematic failings." At the House of Commons question time, Gordon Brown blamed hospital managers. Andy Burnham, the health secretary, spoke of a dysfunctional organisation. Stafford was said to be an isolated incident, but some months later there was a similar report of poor care and over 400 preventable deaths at Basildon and Thurrock Hospitals, also a foundation trust. There were allegations that the problems at Mid Staffordshire and Basildon should have been identified sooner and the Doctor Foster organisation claimed that other hospitals, too, had high mortality rates. Despite its laudable aims, the verdict on ten years of clinical governance must be one of failure.

What, then of medical professionalism? The rise of professional society in the first half of the 20th century was created by education and consolidated by exclusion of the unqualified. The welfare state with the expansion of medical technology and an ageing population increased the demand for the services of professionals. The oil crisis of 1973 and subsequent world recession led, as hard financial times often do, to questioning of attitudes and policies. Schools, universities, and the welfare state were seen as parasitic upon the wealth-creating private sector. Despite this rhetoric from the new political right, expenditure on health continued to rise, but the view gained ground that healthcare needed to be managed.

The new management of the NHS began after the first Thatcher-led government asked Roy Griffiths, Managing Director of Sainsbury's, to examine the problem and advise. His report[5] called for a management structure with devolution to hospital level and he thought that doctors should contribute more to management of the service. It was eight years before devolution occurred with the introduction of trusts in 1991/2. But it was never true devolution. Central control became stronger and all that was really devolved was the enforcement of that control.

The result was that, in the last quarter century, concepts of medical professionalism were sidelined in the drive for central control. But not entirely. Professional standards for modern times were defined in the late 19th and early 20th century writings of physicians such as Sir William Osler, and were part of a culture, taught mainly by example. Although the principles of professionalism were well established, the practice did not keep pace with a changing society and the replacement of paternalism by patient autonomy. Sir Donald Irvine, who was president of the GMC at the time of the Bristol case, spoke of a new professionalism[6], but all

of the core components he described were, in fact, included in the old professionalism which had just not kept pace with changing times. What then is professionalism? We could simply say that, like art or obscenity, it's difficult to define, but everyone knows it when they see it.

The literature on professionalism includes long lists of attributes, 90 in one publication[7], the commonest being altruism, accountability, respect, trustworthiness, responsibility and excellence. Whether professionalism can be taught remains unclear, but it does seem likely that it can be learned. Whilst it might be assessed subjectively, a validated means of measuring professionalism remains elusive. Perhaps we should remember with Einstein that not everything that matters can be measured and not everything that can be measured matters.

There are two aspects of professionalism which I would like to discuss further, first, trust and secondly excellence. Surveys show that the level of trust which patients place in their doctors is high. Nevertheless, society in general is much less trusting than in the past and this distrust extends to all those perceived to hold authority or expertise. Although education is more widespread, society is more complex. Everyone is a layman, except in his own specialty. Distrust is an easy response to that which we don't understand. People are more fearful of risks, not just in medicine, but with everything from nuclear power to genetically modified crops. With doctors, trust will be based mostly on the citizen's expectation that their doctor has gone through a process of selection and education, and be in possession of the skills and qualities that justify their trust.

Onora O'Neill, in her Gifford Lectures[8] of 2001 to the University of Edinburgh and the BBC Reith Lectures[9] of the following year, gave a most lucid exposition on the subject of trust. She cited four reasons for what she described as the culture of suspicion. First, the human rights movement with its emphasis on rights without reference to the corresponding responsibilities. Secondly, current concepts of accountability with paralysing burdens of managerial targets and bureaucratic process. Thirdly, she thought that demands for transparency in the information age had displaced the obligation not to deceive. Finally, she criticised the double standard of public culture, often credulous of its own standard and critical of everyone else's. It may be that wider societal factors are stronger determinants of whether our patients trust us as doctors than anything we do individually or collectively, or even that regulatory bodies might impose.

Now, to excellence. How can it be achieved? Pre-requisites would include the selection of practitioners with the appropriate attributes and providing them with the necessary knowledge and skills. But scientific knowledge and technical skills alone are not enough. The art of medicine is in the judgement that applies the available science and technology to the needs of the individual patient. Excellence is the achievement of the best possible outcome for everyone, which brings me to evidence-based medicine (EBM). Its recent history starts with Professor Archie Cochrane's Rock Carling lecture of 1971 entitled '*Effectiveness and Efficiency: Random Reflections on Health Services'*. His short book of the same title, published in the following year, had a national and international impact which continues until this day. Cochrane's early experience shaped his views. As a young doctor, he found himself in a prisoner of war camp where tuberculosis was rife. Treatments were available, but Cochrane, had no idea which to use or when, and was fearful that some of his interventions might even have been detrimental. After the war he joined the Medical Research Council and, through his attempts to answer clinical questions scientifically, became interested in the conduct of clinical trials – observer error, reproducibility and bias. In his book, he wrote that he had once asked a crematorium worker, who had a contented look on his face, why he found his work so satisfying. The employee replied that he was fascinated by the way in which so much went in and so little came out. Cochrane thought that if the man took a job in the NHS he could increase his job satisfaction even more. The central argument of Effectiveness and Efficiency was that the NHS was spending enough – it was 4% of GDP at that time – but just needed to be more rigorous in ensuring the effectiveness of the interventions offered and the efficiency with which they were delivered.

We move from Archie Cochrane to Dr David Sackett's Department of Clinical Epidemiology and Biostatistics at McMaster University. Sackett, like Cochrane, was interested in examining critically the available research evidence and applying it to clinical practice. The term evidence-based medicine first appeared in an introductory document written by his colleague Gordon Guyatt for residents at McMaster. Interestingly, evidence-based medicine was the second name Guyatt used to describe the practice philosophy. The term scientific medicine which he tried first had aroused hostility amongst his colleagues with its implication that what was practised until then was unscientific medicine.

Evidence-based medicine, as Sackett defined it, was an integration of the best available evidence with clinical expertise and patient values. He described the steps by which this was to be achieved by bringing together and appraising critically the published research. Back to Archie Cochrane who wrote, in 1979: "it is surely a great criticism of our profession that we have not organised a critical summary, by specialty or subspecialty, adapted periodically, of all randomised clinical trials". This took some time, but in 1993 The Cochrane Collaboration was founded as a repository for the Cochrane Library of Systematic Reviews which now has over 4,300 systematic reviews and 625,000 randomised trials available online. It was intended that these reviews would form the basis for practical guidelines – a means of making the large volume of information manageable and therefore applicable as Sackett advocated.

EBM has had its critics, mostly along the lines that it devalues traditional clinical skills and the art of medicine. On the contrary, Sackett and his colleagues went to great lengths to explain that it should enhance clinical medicine. They emphasised that evidence alone was not enough if the clinical skills were not of a high order. Sackett wrote that, because EBM required clinical expertise and involved patient choice, "it cannot result in slavish cook-book approaches to individual patient care.[10]"

So much for recent medical history. Where are we now? Shaw's dilemma of demand exceeding the ability to provide remains a major challenge, probably the major challenge

for modern healthcare. The dilemmas highlighted by Cochrane of the need to make health services effective and efficient remain timely. The NHS has had unprecedented funding in the past ten years, but evidence of commensurate improvement is difficult to find. Take for example the National Cancer Plan of 2000, reminiscent of President Nixon's National Cancer Act signed into law in December 1971. The American plan was to find cures for the major forms of cancer by the bicentenary of the state in 1976. Nixon called for the same kind of effort that split the atom and sent a man to the moon. It might have been good short term politics, but was poor science. Strategy documents were drawn up extending to 1000 pages which Ralph Moss, in his book, *'The Cancer Industry'*[11] said would undoubtedly live on as an example of bureaucratic obscurity. Despite massive expenditure, no cure was found, indeed no significant advance was made in cancer management. Our own UK cancer plan[12] promised survival rates to match the best in Europe by 2010. Like the American plan it has absorbed huge resources and been associated with a massive bureaucracy. We can only hope that the similarities with the Nixon plan end there and that it will produce benefit. However, it must be said that the evidence of its effectiveness, never mind cost-effectiveness, is slow in coming.

Much has been spoken and written about efficiency recently; it's the obvious easy answer to the conflict between demand and supply. Unfortunately, most of the measures taken to achieve it have had little or no basis in evidence, or even in common sense, but were driven by crude arbitrary targets. It's hardly surprising that these have resulted in some poor quality care. As a result of the drive for efficiency, management imperatives have become the major force in healthcare. If we move forward 30 years from Cochrane, the Rock Carling Lecture of 2001 was given by Theodore Marmor, Professor of Public Policy and Management at Yale University. His title was 'Fads in Medical Care Policy and Politics: The Rhetoric and Reality of Managerialism[13]'. His view was that "the managerial attack on the dominance of medical professionalism had helped to deflate public confidence and to increase the probability of proposals threatening professional autonomy". He described how the fads of business management had been transferred to healthcare despite important differences. There was no managerial panacea; it was a complex business, balancing upsides and downsides. Mindless attempts at cost control may, in fact incur costs and reduce the morale of both patients and healthcare professionals. We cannot, of course, have clinical anarchy. There must be rules, but we should remember that compliance is likely to be inversely proportional to their number and complexity.

Thus we come to the nub of the problem of how to achieve effectiveness and efficiency - managerialism versus professionalism, rigid rules versus culture and values. They never should have been in conflict: properly implemented they would have been complementary. Griffiths envisaged that a balance between managers and doctors in management would produce a balance between clinical quality and cost. But increasingly, cost pressures became predominant. The clinical directorate system, despite its theoretical strengths, fails to solve even the simplest issues in service improvement and efficiency. For example, why has something so seemingly simple as making patients' appointments become so complex? And, why should our patients trust us with decisions about their lives and health if we cannot even organise their appointments reliably? Could it be that we've lost sight of the lessons of Cochrane and Sackett and become entangled in the management fads described by Marmor? Governance which was intended to assure professionalism and quality has become an instrument of enforcement, too often of measures which have undermined quality. Sackett, with foresight, wrote "Some fear that evidence-based medicine will be hijacked by purchasers and managers to cut the costs of healthcare. This would not only be a misuse of evidence-based medicine but suggests a fundamental misunderstanding of its financial consequences."

These problems of how to ensure quality and efficiency are not confined to this country. Dr Jerome Groopman, a professor of medicine at Harvard Medical School, in a paper in the New York Review[14] earlier this year, described the conflicting advice given to President Obama from his health advisers. One group advised coercive legislation, aggressively pushing doctors and patients to do what the government defined as best whilst another recommended greater clinical freedom. Groopman made his own position clear, declaring that "The care of patients is complex and choices about treatment involve difficult tradeoffs. That the uncertainties can be erased by mandates from experts is a misconceived panacea".

So, the dilemma remains, but I am not pessimistic. Good ideas come to the surface, eventually. The concepts of EBM and clinical governance are intrinsically sound and should promote the best aspects of professionalism. They have been antipathetic only because they have been misused. Medicine can learn from business, but cannot be run as a business. That clinical excellence and financial control can be reconciled is well demonstrated at the Mayo Clinic. The central tenet of the practice at Mayo is that the needs of the patient come first. It hardly needs to be said for it is evident that the concept pervades all levels of the organisation. A recent book, *Management Lessons from the Mayo Clinic*[15] describes the management structure and processes. The currency of respect is clinical excellence. Physicians have as much at stake as do managers to ensure the financial viability of the institution. Managers have at much at stake as physicians to ensure good patient care. Leaders are invited; physicians who appear conspicuously ambitious for leadership have a high chance of rejection. The committee system works to achieve consensus which is easier where there is mutual respect and shared objectives. None of this is new. Peter Drucker, the management academic wrote more than 20 years ago about the need for organisations to have values and pointed out the differences between businesses and not-for-profit organisations.

Mervyn King has described the principles of good governance in his short book, *'The Corporate Citizen'*. King is well-placed to combine the business and professional, having been a former Judge of the High Court in South Africa and chairman and director of several companies. He wrote that "Good governance will not result from a mindless quantitative compliance with a governance code or rules. Good Governance involves fairness, accountability, responsibility and transparency on a foundation of intellectual honesty.[16]"

A paper in the Harvard Business Review of April 2010 entitled 'Turning Doctors into Leaders' focused on the need to dismantle the current dysfunctional processes in healthcare. Delivery of care should be organised around patients' needs with services focused on outcome rather than activity. It was gratifying to see, in a business journal, recognition of the primacy of clinical care and outcome, and powerful advocacy of the view that leadership should be clinical.

And so I come back to the new students. I hope you're not discouraged by the problems I've described. You have chosen one of the most fascinating, challenging and rewarding occupations anyone could have. You are living in interesting times. In my working lifetime, we have seen the failure of both socialist and free market ideologies in handling public services. We now hear public discussion of the need to find new ways in which society might organise its affairs better – how much the state should intervene in people's lives, what services it should, and should not, provide, and how it should deliver them effectively and efficiently. The health service is a paradigm for these larger political issues. Many of the answers are already available in the medical and management literature. If I have encouraged at least some of you to become interested in these wider aspects of healthcare, I shall be well satisfied. I wish you every success in the future and it is my hope that your generation will be more effective in dealing with some of these doctors' dilemmas than has mine.

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